FAX to JOAN HALL
@ 414-257-7575

Wraparound Milwaukee Integrated Provider Network

ADD DIRECT SERVICE PROVIDER SHEET

Entered by:_____
Date: _____

Date_____ Agency Name _____

Contact Person _____ Phone Number _____

NOTE: Forms that are NOT dated and signed will not be processed.				CREDENTIALS CHECK ONLY IF ATTACHED							
(Check Box if NEW STAFF) PRINT **Provider Name** (Last Name, First Name)	One Servuce Per Line **REQUIRED** **Service Code**	Service Code and Service Name Must Match **Service Name**	**Required for AODA and Mental Health Providers** **MA Number**	15 Hr Training Certificate	WBC Certification	Wisc. State License	3000 Hour Letter	EDS Letter	University/College Degree	Resume or Letter of Recommendation	Wraparound Use Only
New Staff ☐											
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Background checks have been completed on all of the above staff within the last 4 years and are available upon request at the above agency.

Submit Wisconsin State Dept. of Justice and/or Dept. Regulation and Licensing report to Wraparound for review if criminal record, denial or revocation is noted.

Prepared by: _____ Date: _____